FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042044

Facility Name: Washington Heights N H

Address: 1010 West 95Th St (Number) Chicago (City) 60643 (Zip Code)

County: Cook

Telephone Number: (773) 298-1177 **Fax #** (773) 298-1666

IDPA ID Number: 364100431001

Date of Initial License for Current Owners: 10/24/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Edward N. Slack, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	228	Skilled (SNF)	228	83,220	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	228	TOTALS	228	83,220	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,699	248	8,406	14,353	8
9	SNF/PED					9
10	ICF	57,619	2,508		60,127	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	63,318	2,756	8,406	74,480	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.50%

D. How many bed-hold days during this year were paid by Public Aid? 1,372 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/24/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/24/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 28 and days of care provided 8,406

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	326,406	60,107	20,906	407,419		407,419	(13,288)	394,131			1
2	Food Purchase		285,428		285,428	(36,135)	249,293	3,988	253,281			2
3	Housekeeping	231,527	50,777		282,304		282,304	(5,635)	276,669			3
4	Laundry	87,031	21,339		108,370		108,370		108,370			4
5	Heat and Other Utilities			249,285	249,285		249,285	1,951	251,236			5
6	Maintenance	57,316		245,999	303,315		303,315	6,490	309,805			6
7	Other (specify):*							1,804	1,804			7
8	**TOTAL General Services**	702,280	417,651	516,190	1,636,121	(36,135)	1,599,986	(4,690)	1,595,296			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	2,876,599	78,650	160,028	3,115,277		3,115,277	5,742	3,121,019			10
10a	Therapy	105,252	1,437	3,057	109,746		109,746	661	110,407			10a
11	Activities	158,981	5,302	2,889	167,172		167,172	35	167,207			11
12	Social Services	143,589		15,842	159,431		159,431	1,406	160,837			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							15,283	15,283			15
16	**TOTAL Health Care and Programs**	3,284,421	85,389	190,816	3,560,626		3,560,626	23,127	3,583,753			16
	C. General Administration											
17	Administrative	38,779		303,482	342,261		342,261	89,925	432,186			17
18	Directors Fees											18
19	Professional Services			386,928	386,928	(3,800)	383,128	(303,443)	79,685			19
20	Dues, Fees, Subscriptions & Promotions			71,275	71,275		71,275	(32,564)	38,711			20
21	Clerical & General Office Expenses	79,648	29,349	197,046	306,043		306,043	68,770	374,813			21
22	Employee Benefits & Payroll Taxes			756,366	756,366	36,135	792,501	(36,088)	756,413			22
23	Inservice Training & Education			664	664		664		664			23
24	Travel and Seminar			340	340		340	1,542	1,882			24
25	Other Admin. Staff Transportation			9,808	9,808		9,808	(9,516)	292			25
26	Insurance-Prop.Liab.Malpractice			217,602	217,602		217,602	1,613	219,215			26
27	Other (specify):*							35,258	35,258			27
28	**TOTAL General Administration**	118,427	29,349	1,943,511	2,091,287	32,335	2,123,622	(184,503)	1,939,119			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,105,128	532,389	2,650,517	7,288,034	(3,800)	7,284,234	(166,066)	7,118,168			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Washington Heights N H #0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			84,345	84,345		84,345	315,321	399,666			30
31	Amortization of Pre-Op. & Org.			1,414	1,414		1,414		1,414			31
32	Interest			53,236	53,236		53,236	664,196	717,432			32
33	Real Estate Taxes			354,412	354,412	3,800	358,212	2,898	361,110			33
34	Rent-Facility & Grounds			1,266,222	1,266,222		1,266,222	(1,261,425)	4,797			34
35	Rent-Equipment & Vehicles			12,647	12,647		12,647	2,386	15,033			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,772,276	1,772,276	3,800	1,776,076	(276,624)	1,499,452			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		333,694	405,501	739,195		739,195	(11,722)	727,473			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			124,830	124,830		124,830		124,830			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		333,694	530,331	864,025		864,025	(11,722)	852,303			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,105,128	866,083	4,953,124	9,924,335		9,924,335	(454,411)	9,469,924			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	8,382	30		9
10	Interest and Other Investment Income	(228,202)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(105)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(84,000)	21		24
25	Fund Raising, Advertising and Promotional	(10,552)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(148)	20		28
29	Other-Attach Schedule	(50,169)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (364,794)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(89,617)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (89,617)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (454,411)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Washington Heights N H

ID# 0042044

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	IL Council on LTC - COPE Dues	$ (2,874)	20	1
2	Jury Duty	(70)	21	2
3	Collection Expense	(4,089)	21	3
4	Bank Charges	(5,067)	21	4
5	Theft Loss	(985)	21	5
6	Amortization (Bldg Co Loan Fees)	(12,723)	31	6
7	Nonallowable Mgt Fees	(24,000)	17	7
8	Building Co Filing Fees	(300)	21	8
9	Building Co Bank Charges	(61)	21	9
10				10
11				11
12				12
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98				98
99				99
100				100
101	**Total**	(50,169)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary			64		(4,063)	(5,441)		(3,848)				(13,288)	1
2	Food Purchase	(105)		(115)			4,208						3,988	2
3	Housekeeping					1,223			(6,858)				(5,635)	3
4	Laundry													4
5	Heat and Other Utilities			1,951									1,951	5
6	Maintenance			2,036	55	4,477	12		(90)				6,490	6
7	Other (specify):*				262	1,235	307						1,804	7
8	**TOTAL General Services**	(105)		3,936	317	2,872	(914)		(10,796)				(4,690)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			258	230	14,138			(8,884)				5,742	10
10a	Therapy				1	660							661	10a
11	Activities			35									35	11
12	Social Services				1,209	197							1,406	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				13,458	1,825							15,283	15
16	**TOTAL Health Care and Programs**			293	14,898	16,820			(8,884)				23,127	16
	C. General Administration													
17	Administrative	(24,000)			99,482	14,223	220						89,925	17
18	Directors Fees													18
19	Professional Services			(303,515)			72						(303,443)	19
20	Fees, Subscriptions & Promotions	(13,574)	300	(19,310)			20						(32,564)	20
21	Clerical & General Office Expenses	(94,572)	61	21,699		141,114	468						68,770	21
22	Employee Benefits & Payroll Taxes				(35,346)			(322)	(420)				(36,088)	22
23	Inservice Training & Education													23
24	Travel and Seminar			938			604						1,542	24
25	Other Admin. Staff Transportation			(9,516)									(9,516)	25
26	Insurance-Prop.Liab.Malpractice			1,613									1,613	26
27	Other (specify):*				16,065	19,193							35,258	27
28	**TOTAL General Administration**	(132,146)	361	(308,091)	80,201	174,530	1,384	(322)	(420)				(184,503)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(132,251)	361	(303,862)	95,416	194,222	470	(322)	(20,100)				(166,066)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Washington Heights N H # 0042044 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	8,382	296,549	10,390									315,321	30
31	Amortization of Pre-Op. & Org.	(12,723)	12,723											31
32	Interest	(228,202)	871,945	20,448			5						664,196	32
33	Real Estate Taxes			2,898									2,898	33
34	Rent-Facility & Grounds		(1,266,222)	4,797									(1,261,425)	34
35	Rent-Equipment & Vehicles			2,269			117						2,386	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(232,543)	(85,005)	40,802			122						(276,624)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(4,911)		(6,811)				(11,722)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**						(4,911)		(6,811)				(11,722)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(364,794)	(84,643)	(263,060)	95,416	194,222	(4,319)	(322)	(26,910)				(454,411)	45

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Washington Heights Property, LLC	Building Co	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 1,266,222	Washington Heights Property LLC		$	$ (1,266,222)	1
2	V	32	Interest Income/Expense	51,046	Washington Heights Property LLC		922,991	871,945	2
3	V	21	Bank Charges		Washington Heights Property LLC		61	61	3
4	V	20	Filing Fees		Washington Heights Property LLC		300	300	4
5	V	30	Depreciation Expense		Washington Heights Property LLC		296,549	296,549	5
6	V	31	Amortization		Washington Heights Property LLC		12,723	12,723	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,317,268			$ 1,232,624	$ * (84,643)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Care Centers, Inc.	100.00%	$ 64	$ 64	15
16	V	05	Utilities		Care Centers, Inc.	100.00%	1,951	1,951	16
17	V	06	Maintenance		Care Centers, Inc.	100.00%	2,036	2,036	17
18	V	10	Nursing	38	Care Centers, Inc.	100.00%	296	258	18
19	V	11	Activities		Care Centers, Inc.	100.00%	35	35	19
20	V	19	Professional Fees	316,558	Care Centers, Inc.	100.00%	13,043	(303,515)	20
21	V	20	Dues and Subscriptions	20,805	Care Centers, Inc.	100.00%	1,495	(19,310)	21
22	V	21	Office & Clerical		Care Centers, Inc.	100.00%	21,699	21,699	22
23	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	938	938	23
24	V	26	Insurance		Care Centers, Inc.	100.00%	1,613	1,613	24
25	V	30	Depreciation		Care Centers, Inc.	100.00%	10,390	10,390	25
26	V	32	Interest		Care Centers, Inc.	100.00%	20,448	20,448	26
27	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	2,898	2,898	27
28	V	34	Rent - Building		Care Centers, Inc.	100.00%	4,797	4,797	28
29	V	35	Rent - Equipment and Auto		Care Centers, Inc.	100.00%	2,269	2,269	29
30	V	25	Bus Reimbursement	9,516	Care Centers, Inc.	100.00%		(9,516)	30
31	V	02	Food	115	Care Centers, Inc.	100.00%		(115)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 347,032			$ 83,972	$ * (263,060)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance Salary	$ 2,082	Care Centers, Inc.	100.00%	$ 2,137	$ 55	15
16	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	262	262	16
17	V	10	Nursing Salary	88,205	Care Centers, Inc.	100.00%	88,435	230	17
18	V	10a	Rehab Salary	33	Care Centers, Inc.	100.00%	34	1	18
19	V	11	Activity Salary	597	Care Centers, Inc.	100.00%	597		19
20	V	12	Social Service Salary	14,786	Care Centers, Inc.	100.00%	15,995	1,209	20
21	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	13,458	13,458	21
22	V	17	Administration Salary		Care Centers, Inc.	100.00%	99,482	99,482	22
23	V	21	Office Salary	29,197	Care Centers, Inc.	100.00%	29,197		23
24	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	16,065	16,065	24
25	V	22	Employee Benefits	35,346	Care Centers, Inc.	100.00%		(35,346)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 170,246			$ 265,662	$ * 95,416	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	$ 8,322	Care Centers, Inc.	100.00%	$ 4,259	$ (4,063)	15
16	V	03	Housekeeping Salary		Care Centers, Inc.	100.00%	1,223	1,223	16
17	V	06	Maintenance Salary		Care Centers, Inc.	100.00%	4,477	4,477	17
18	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	1,235	1,235	18
19	V	10	Nursing Salary		Care Centers, Inc.	100.00%	14,138	14,138	19
20	V	10a	Rehab Salary		Care Centers, Inc.	100.00%	660	660	20
21	V	12	Social Services Salary		Care Centers, Inc.	100.00%	197	197	21
22	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	1,825	1,825	22
23	V	17	Administration Salary		Care Centers, Inc.	100.00%	14,223	14,223	23
24	V	21	Office Salary		Care Centers, Inc.	100.00%	141,114	141,114	24
25	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	19,193	19,193	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 8,322			$ 202,544	$ * 194,222	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 9,019	Care Centers, Inc. - Health Systems Division	100.00%	$ 1,218	$ (7,801)	15
16	V	02	Food		Care Centers, Inc. - Health Systems Division	100.00%	4,208	4,208	16
17	V	06	Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	12	12	17
18	V	17	Administration		Care Centers, Inc. - Health Systems Division	100.00%	220	220	18
19	V	19	Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	72	72	19
20	V	20	Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	20	20	20
21	V	21	Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	468	468	21
22	V	24	Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	604	604	22
23	V	32	Interest Expense		Care Centers, Inc. - Health Systems Division	100.00%	5	5	23
24	V	35	Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	117	117	24
25	V	39	Ancillary Enteral Supplies	9,207	Care Centers, Inc. - Health Systems Division	100.00%	4,296	(4,911)	25
26	V	01	Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	2,360	2,360	26
27	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	307	307	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 18,226			$ 13,907	$ * (4,319)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INSURANCE	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 76,438	$ 76,438	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	76,760	CCS EMPLOYEE BENEFIT GROUP	100.00%		(76,760)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 76,760			$ 76,438	$ * (322)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	DIETARY	$ 29,234	XCEL MEDICAL SUPPLY, LLC	100.00%	$ 25,386	$ (3,848)	15
16	V	02	FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%			16
17	V	03	HOUSEKEEPING	52,102	XCEL MEDICAL SUPPLY, LLC	100.00%	45,244	(6,858)	17
18	V	04	LAUNDRY		XCEL MEDICAL SUPPLY, LLC	100.00%			18
19	V	06	REPAIRS & MAINTENANCE	687	XCEL MEDICAL SUPPLY, LLC	100.00%	597	(90)	19
20	V	10	NURSING	67,490	XCEL MEDICAL SUPPLY, LLC	100.00%	58,607	(8,884)	20
21	V	10A	THERAPY		XCEL MEDICAL SUPPLY, LLC	100.00%			21
22	V	12	SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%			22
23	V	21	CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%			23
24	V	22	EMPLOYEE BENEFITS	3,189	XCEL MEDICAL SUPPLY, LLC	100.00%	2,769	(420)	24
25	V	39	ANCILLARY	51,742	XCEL MEDICAL SUPPLY, LLC	100.00%	44,931	(6,811)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 204,444			$ 177,534	$ * (26,910)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	David Aronin	Owner	Administrative	0.89%	See Attached	2.00	4.00%	Alloc Salary	$ 4,220	17-7	1
2	Eric Rothner	Relative	Administrative	0.00%	See Attached	1.58	2.87%	Mgt Fee	180,000	17-3	2
3	Norm Goldberg	Owner	Administrative	1.77%	See Attached	2.50	4.72%	Alloc Salary	5,089	17-7	3
4	Mark Steinberg	Relative	Administrative	0.00%	See Attached	2.50	4.95%	Alloc Salary	1,974	17-7	4
5	Adam Vales	Relative	Clerical	5.75%	See Attached	0.39	0.98%	Alloc Salary	306	22-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 191,589		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,764,895	42	$ 1,527	$	74,480	$ 64	1
2	05	Utilities	Patient Days	1,764,895	42	46,229		74,480	1,951	2
3	06	Maintenance	Patient Days	1,764,895	42	48,251		74,480	2,036	3
4	10	Nursing	Patient Days	1,764,895	42	7,018		74,480	296	4
5	11	Activities	Patient Days	1,764,895	42	838		74,480	35	5
6	19	Professional Fees	Patient Days	1,764,895	42	309,074		74,480	13,043	6
7	20	Dues and Subscriptions	Patient Days	1,764,895	42	35,428		74,480	1,495	7
8	21	Office & Clerical	Patient Days	1,764,895	42	523,091		74,480	21,699	8
9	24	Travel and Seminar	Patient Days	1,764,895	42	22,233		74,480	938	9
10	26	Insurance	Patient Days	1,764,895	42	38,230		74,480	1,613	10
11	30	Depreciation	Patient Days	1,764,895	42	246,194		74,480	10,390	11
12	32	Interest	Patient Days	1,764,895	42	484,531		74,480	20,448	12
13	33	Real Estate Taxes	Patient Days	1,764,895	42	68,681		74,480	2,898	13
14	34	Rent - Building	Patient Days	1,764,895	42	113,677		74,480	4,797	14
15	35	Rent - Equipment & Auto	Patient Days	1,764,895	42	53,777		74,480	2,269	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,998,780	$		$ 83,972	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance Salary	Direct Cost			213,393	213,393		2,137	1
2	07	Emp. Ben. - Gen. Serv.	Direct Cost			26,918			262	2
3	10	Nursing Salary	Direct Cost			976,718	976,718		88,435	3
4	10a	Rehab Salary	Direct Cost			103,898	103,898		34	4
5	11	Activity Salary	Direct Cost			10,902	10,902		597	5
6	12	Social Service Salary	Direct Cost			306,863	306,863		15,995	6
7	15	Emp. Ben. - Healthcare	Direct Cost			174,348			13,458	7
8	17	Administration Salary	Direct Cost			1,191,200	1,191,200		99,482	8
9	21	Office Salary	Direct Cost			698,886	698,886		29,197	9
10	27	Emp. Ben. - Gen. Admin.	Direct Cost			238,998			16,065	10
11	22	Employee Benefits								11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,942,124	$ 3,501,860		$ 265,662	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Patient Days	1,764,895	42	100,923	100,923	74,480	4,259	1
2	03	Housekeeping Salary	Patient Days	1,764,895	42	28,979	28,979	74,480	1,223	2
3	06	Maintenance Salary	Patient Days	1,764,895	42	106,088	106,088	74,480	4,477	3
4	07	Emp. Ben. - Gen. Serv.	Patient Days	1,764,895	42	29,264		74,480	1,235	4
5	10	Nursing Salary	Patient Days	1,764,895	42	335,028	335,028	74,480	14,138	5
6	10a	Rehab Salary	Patient Days	1,764,895	42	15,649	15,649	74,480	660	6
7	12	Social Services Salary	Patient Days	1,764,895	42	4,661	4,661	74,480	197	7
8	15	Emp. Ben. - Healthcare	Patient Days	1,764,895	42	43,235		74,480	1,825	8
9	17	Administration Salary	Patient Days	1,764,895	42	337,043	337,043	74,480	14,223	9
10	21	Office Salary	Patient Days	1,764,895	42	3,343,864	3,343,864	74,480	141,114	10
11	27	Emp. Ben. - Gen. Admin.	Patient Days	1,764,895	42	454,813		74,480	19,193	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,799,547	$ 4,272,235		$ 202,544	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	2,073,579		138,556		18,226	1,218	1
2	02	Food	Billable Income	2,073,579		852,614		18,226	4,208	2
3	06	Maintenance	Billable Income	2,073,579		1,311		18,226	12	3
4	17	Administration	Billable Income	2,073,579		25,000		18,226	220	4
5	19	Professional Fees	Billable Income	2,073,579		8,170		18,226	72	5
6	20	Dues & Subscriptions	Billable Income	2,073,579		2,312		18,226	20	6
7	21	Office & Clerical	Billable Income	2,073,579		53,285		18,226	468	7
8	24	Travel & Seminar	Billable Income	2,073,579		68,680		18,226	604	8
9	32	Interest Expense	Billable Income	2,073,579		571		18,226	5	9
10	35	Rent - Equipment & Auto	Billable Income	2,073,579		13,336		18,226	117	10
11	39	Ancillary Enteral Supplies	Billable Income	2,073,579		114,955		18,226	4,296	11
12	01	Dietary - Salary	Billable Income	2,073,579		268,554	268,554	18,226	2,360	12
13	07	Emp. Ben. - Gen. Serv.	Billable Income	2,073,579		34,942		18,226	307	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,582,287	$ 268,554		$ 13,907	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURA	DIRECT ALLOCATION			$	$		$ 76,438	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 76,438	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY, LLC
Street Address: 2201 MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation			$	$		$ 25,386	1
2	02	FOOD	Direct Allocation							2
3	03	HOUSEKEEPING	Direct Allocation						45,244	3
4	04	LAUNDRY	Direct Allocation							4
5	06	REPAIRS & MAINTENANCE	Direct Allocation						597	5
6	10	NURSING	Direct Allocation						58,607	6
7	10A	THERAPY	Direct Allocation							7
8	12	SOCIAL SERVICE	Direct Allocation							8
9	21	CLERICAL & GENERAL OFFIC	Direct Allocation							9
10	22	EMPLOYEE BENEFITS	Direct Allocation						2,769	10
11	39	ANCILLARY	Direct Allocation						44,931	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 177,534	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Corus Bank		X	Mortgage			$	$ 11,986,821			$ 976,227	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6												6
7												7
8	See Supplemental Schedule										20,453	8
9	TOTAL Facility Related						$	$ 11,986,821			$ 996,680	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13	See Supplemental Schedule										(279,248)	13
14	TOTAL Non-Facility Related						$	$			$ (279,248)	14
15	TOTALS (line 9+line14)						$	$ 11,986,821			$ 717,432	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ 0** **Line # N/A**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Care Center Allocation		X				$	$			$ 20,448	8
9	Care Ctr/Health Div Alloc		X								5	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										20,453	14
	B. Non-Facility Related*											
15	Interest Income-Bldg Co						$	$			$ (51,046)	15
16	Interest Income										(228,202)	16
17												17
18												18
19												19
20	TOTAL Non-Facility Related										(279,248)	20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	364,097	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	353,391	2
3. Under or (over) accrual (line 2 minus line 1).	$	(10,706)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	368,016	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	3,800	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	361,110	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	356,222	8
	1999	353,852	9
	2000	337,917	10
	2001	346,759	11
	2002	350,493	12

2002 Accrual - $350,493*1.05=$368,018

Allocation from Care Centers=2898.41

Urban Real Estate - $3800.00 Appraisal Fee

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Washington Heights N H COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042044

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	25-05-423-0001-0000	Long Term Care Property	$ 1,335.09	$ 1,335.09
2.	25-05-423-0002-0000	Long Term Care Property	$ 1,473.85	$ 1,473.85
3.	25-05-423-0003-0000	Long Term Care Property	$ 1,687.97	$ 1,687.97
4.	25-05-423-0004-0000	Long Term Care Property	$ 1,633.82	$ 1,633.82
5.	25-05-423-0005-0000	Long Term Care Property	$ 8,442.27	$ 8,442.27
6.	25-05-423-0006-0000	Long Term Care Property	$ 43,180.60	$ 43,180.60
7.	25-05-423-0007-0000	Long Term Care Property	$ 52,069.48	$ 52,069.48
8.	25-05-423-0008-0000	Long Term Care Property	$ 134,474.31	$ 134,474.31
9.	25-05-423-0009-0000	Long Term Care Property	$ 106,195.63	$ 106,195.63
10.	Care Center Allocation	Home Office	$ 68,681.49	$ 2,898.41
		TOTALS	$ 419,174.51	$ 353,391.43

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Washington Heights N H COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042044

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 90,255 B. General Construction Type: Exterior Brick Frame Masonary/Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 8,033
2. Number of Years Over Which it is Being Amortized: 2 Years
3. Current Period Amortization: 1,414
4. Dates Incurred:

Nature of Costs: Financing Fees/Cost Segregation Svcs
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	85,244	1994	$ 251,898	1
2	Alloc CCI			21,455	2
3	TOTALS	85,244		$ 273,353	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1996	21,522		20	1,077	1,077	8,026	9
10	Various			1997	179,381		20	8,971	8,971	57,888	10
11	Various			1998	71,893		20	3,596	3,596	19,873	11
12	Various			1999	54,109		20	2,705	(2,705)	12,024	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		10,226,094	242,970		254,542	11,572	1,791,832	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		81,154	2,713		2,827	114	801	68
69	Financial Statement Depreciation			48,828			(48,828)		69
70	TOTAL (lines 4 thru 69)		$ 10,634,153	$ 294,511		$ 273,718	$ (26,203)	$ 1,890,444	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 10,634,153	$ 294,511		$ 273,718	$ (20,793)	$ 1,890,444	1
2	Plumbing Renov	2000	875		20	44	44	176	2
3	Sewer Renov	2000	1,330		20	67	67	267	3
4	Generator Renov	2000	551		20	55	55	220	4
5	Cleaning	2000	3,471		20	174	174	681	5
6	Sewer Renov	2000	503		20	25	25	98	6
7	Sewer Install	2000	8,200		20	410	410	1,606	7
8	Plumbing Renov	2000	1,370		20	69	69	269	8
9	Bedspreads	2000	1,717		20	86	86	337	9
10	Hot Water Heaters	2000	1,847		20	92	92	361	10
11	Doors	2000	2,500		20	250	250	979	11
12	Bedspreads	2000	5,421		20	271	271	1,039	12
13	Pipe Installation	2000	11,000		20	550	550	2,063	13
14	Rodding	2000	2,030		20	102	102	382	14
15	Fence Repair	2000	850		20	43	43	157	15
16	Electrical Renov	2000	885		20	89	89	325	16
17	Basement Floor	2000	34,650		20	1,733	1,733	6,209	17
18	Fire Alarm Panel	2000	4,064		20	406	406	1,456	18
19	Signs	2000	1,683		20	84	84	294	19
20	Water Heater Repair	2000	2,144		20	214	214	750	20
21	Electric Wiring	2000	985		20	49	49	173	21
22	Landscaping	2000	1,200		20	60	60	210	22
23	Landscaping	2000	2,085		20	104	104	365	23
24	Hvac Repair	2000	595		20	30	30	103	24
25	Rodding	2000	1,280		20	64	64	219	25
26	Repair & Clean Drape	2000	920		20	46	46	157	26
27	Backflow Certificati	2000	840		20	42	42	144	27
28	Doors	2000	1,614		20	81	81	276	28
29	Hvac Repair	2000	698		20	35	35	120	29
30	Inspect Underground	2000	1,270		20	64	64	212	30
31	Door Frames	2000	2,000		20	100	100	333	31
32	Office	2000	3,260		20	163	163	543	32
33	Hvac Repair	2000	638		20	32	32	107	33
34	TOTAL (lines 1 thru 33)		$ 10,736,629	$ 294,511		$ 279,352	$ (15,159)	$ 1,911,075	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 10,736,629	$ 294,511		$ 279,352	$ (15,159)	$ 1,911,075	1
2	Hvac Repair	2000	(329)		20	(16)	(16)	(54)	2
3	3Rd Floor Corridor	2001	11,766		20	588	588	1,765	3
4	Carpeting	2001	20,162		20	1,008	1,008	3,024	4
5	Pump	2001	1,175		20	59	59	177	5
6	Pump	2001	665		20	33	33	100	6
7	American Eagle Detec	2001	1,450		20	73	73	212	7
8	Hvac Repair	2001	887		20	44	44	129	8
9	Fire Alarm R&M	2001	2,282		20	114	114	333	9
10	Hot Water Heater	2001	6,520		20	326	326	924	10
11	American Eagle Detec	2001	1,450		20	73	73	206	11
12	Amer Edge Detector E	2001	1,450		20	73	73	200	12
13	Fence Repair	2001	562		20	28	28	75	13
14	Boiler R & M	2001	612		20	31	31	82	14
15	Hot Water Heater	2001	4,564		20	228	228	589	15
16	Hvac Repair	2001	767		20	38	38	99	16
17	Hvac Repair	2001	973		20	49	49	122	17
18	Plumbing R&M	2001	625		20	31	31	76	18
19	Inspect Underground	2001	798		20	40	40	93	19
20	Cleanout Sewer	2001	2,980		20	149	149	348	20
21	Backflow Service	2001	860		20	43	43	100	21
22	Paint	2001	690		20	35	35	75	22
23	Lift	2002	2,149		20	215	215	430	23
24	Stain Glass	2002	695		20	70	70	139	24
25	Basement Ramp Exit Door	2002	1,116		20	112	112	223	25
26	Patio Awning	2002	4,400		20	440	440	880	26
27	3Rd Floor Cafeteria Floor	2002	5,772		20	577	577	1,154	27
28	Repair On Sprinkler System	2002	1,233		20	247	247	493	28
29	Replace Pump	2002	1,562		20	312	312	625	29
30	Concrete Paving	2002	561		20	56	56	108	30
31	Roofing R&M	2002	950		20	95	95	182	31
32	A/C Repair	2002	506		20	101	101	194	32
33	A/C Repair	2002	816		20	163	163	313	33
34	TOTAL (lines 1 thru 33)		$ 10,817,298	$ 294,511		$ 284,787	$ (9,724)	$ 1,924,491	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 10,817,298	$ 294,511		$ 284,787	$ (9,724)	$ 1,924,491	1
2	Valve Repair	2002	844		20	169	169	324	2
3	A/C Repair	2002	585		20	117	117	224	3
4	A/C Repair	2002	870		20	174	174	334	4
5	A/C Repair	2002	684		20	137	137	262	5
6	R&M Fan Coil Units	2002	1,562		20	312	312	599	6
7	R&M Fan Coil Units	2002	863		20	173	173	331	7
8	A/C Repair	2002	506		20	101	101	194	8
9	A/C Repair	2002	863		20	173	173	302	9
10	Phone Jacks	2002	925		20	93	93	162	10
11	Phone Jacks	2002	925		20	93	93	154	11
12	A/C Repair	2002	546		20	109	109	173	12
13	Drapes	2002	932		20	93	93	148	13
14	R&M Fan Coil Units	2002	863		20	173	173	273	14
15	Carpeting	2002	29,566		20	2,957	2,957	4,435	15
16	R&M Fan Coil Units	2002	868		20	174	174	260	16
17	A/C Repair	2002	530		20	106	106	159	17
18	Plumbing R&M	2002	860		20	172	172	244	18
19	Flooring	2002	12,986		20	1,299	1,299	1,623	19
20	Sidewalk R&M	2002	1,820		20	182	182	228	20
21	Carpeting, Material, Labor & Tax	2002	4,381		20	438	438	548	21
22	Pipe R&M	2002	2,200		20	220	220	257	22
23	A/C Repair	2002	1,147		20	115	115	134	23
24	Draperies	2002	774		20	77	77	90	24
25	Crackfilling	2002	4,174		20	417	417	487	25
26	Ductwork	2002	1,740		20	174	174	203	26
27	Parkway Lighting	2002	744		20	74	74	87	27
28	Valve Repair	2002	781		20	156	156	182	28
29	Ceiling Tile	2003	585		20	59	59	59	29
30	Elevator Repair	2003	2,529		20	126	126	126	30
31	Exit Doors	2003	1,180		20	30	30	30	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,895,131	$ 294,511		$ 293,480	$ (1,031)	$ 1,937,123	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 10,895,131	$ 294,511		$ 293,480	$ (1,031)	$ 1,937,123	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,895,131	$ 294,511		$ 293,480	$ (1,031)	$ 1,937,123	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 10,895,131	$ 294,511		$ 293,480	$ (1,031)	$ 1,937,123	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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17									17
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19									19
20									20
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,895,131	$ 294,511		$ 293,480	$ (1,031)	$ 1,937,123	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 10,895,131	$ 294,511		$ 293,480	$ (1,031)	$ 1,937,123	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,895,131	$ 294,511		$ 293,480	$ (1,031)	$ 1,937,123	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 10,895,131	$ 294,511		$ 293,480	$ (1,031)	$ 1,937,123	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,895,131	$ 294,511		$ 293,480	$ (1,031)	$ 1,937,123	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 10,895,131	$ 294,511		$ 293,480	$ (1,031)	$ 1,937,123	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,895,131	$ 294,511		$ 293,480	$ (1,031)	$ 1,937,123	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 10,895,131	$ 294,511		$ 293,480	$ (1,031)	$ 1,937,123	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,895,131	$ 294,511		$ 293,480	$ (1,031)	$ 1,937,123	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 10,895,131	$ 294,511		$ 293,480	$ (1,031)	$ 1,937,123	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,895,131	$ 294,511		$ 293,480	$ (1,031)	$ 1,937,123	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1996		$ 10,226,094	$ 242,970		$ 254,542	$ 11,572	$ 1,791,832	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-BLDG, Line 70 for total

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
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58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 10,226,094	$ 242,970		$ 254,542	$ 11,572	$ 1,791,832	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	CareCenters Inc Alloc		2002		$ 29,566	$ 739		$ 739	$	$ 801	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CareCenters Inc Alloc			2002	27,375	1,369	20	1,483	114		9
10	CareCenters Inc Alloc			2003	24,213	605	20	605			10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 81,154	$ 2,713		$ 2,827	$ 114	$ 801	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 923,351	$ 93,097	$ 99,822	$ 6,725	10	$ 648,465	71
72	Current Year Purchases	43,222	352	3,040	2,688	10	3,040	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 966,573	$ 93,449	$ 102,862	$ 9,413		$ 651,505	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	CCI Allocation	AUTO-CCI ALLOCATION		$ 30,744	$ 3,323	$ 3,323	$	5	$ 24,192	76
77										77
78										78
79										79
80	TOTALS			$ 30,744	$ 3,323	$ 3,323	$		$ 24,192	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 12,165,801	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 391,283	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 399,665	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 8,382	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,612,820	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions	CCI Allocation			4,797			4
5								5
6								6
7	TOTAL				$ 4,797 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 15,033 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 180,459	$		$ 180,459	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			27,851			27,851	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			197,191			197,191	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				179,512		179,512	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						154,182		154,182	13
14	TOTAL			$		$ 405,501	$ 333,694		$ 739,195	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N H **#** 0042044 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/03 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 48,756	$ (1,561,540)	1
2	Cash-Patient Deposits	46,252	46,252	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,115,764	1,483,782	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	263,646	263,646	6
7	Other Prepaid Expenses	3,498	3,498	7
8	Accounts Receivable (owners or related parties)		1,011,741	8
9	Other(specify): See Attached Schedule	4,638,159	4,638,159	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,116,075	$ 5,885,538	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		251,898	13
14	Buildings, at Historical Cost		8,473,923	14
15	Leasehold Improvements, at Historical Cost	509,374	944,438	15
16	Equipment, at Historical Cost	312,823	2,298,250	16
17	Accumulated Depreciation (book methods)	(361,549)	(4,138,806)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		61,179	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 460,648	$ 7,890,882	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,576,723	$ 13,776,420	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 769,659	$ 1,137,675	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	45,308	45,308	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	323,951	323,951	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,986	16,986	31
32	Accrued Real Estate Taxes(Sch.IX-B)	368,016	368,016	32
33	Accrued Interest Payable		77,617	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,033,556	1,038,668	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,557,476	$ 3,008,221	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		11,986,821	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 11,986,821	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,557,476	$ 14,995,042	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,019,247	$ (1,218,622)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,576,723	$ 13,776,420	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,717,999	1
2	Restatements (describe):		2
3	**Adjust Accum Depreciation to GAAP**	52,998	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,770,997	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	351,450	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(103,200)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 248,250	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,019,247	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,780,162	1
2	Discounts and Allowances for all Levels	(2,004,418)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,775,744	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,859,415	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,859,415	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	188,225	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	37,303	19
20	Radiology and X-Ray	12,100	20
21	Other Medical Services	174,676	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 412,304	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	228,202	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 228,202	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	120	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 120	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,275,785	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,636,121	31
32	Health Care	3,560,626	32
33	General Administration	2,091,287	33
	B. Capital Expense		
34	Ownership	1,772,276	34
	C. Ancillary Expense		
35	Special Cost Centers	739,195	35
36	Provider Participation Fee	124,830	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,924,335	40
41	**Income before Income Taxes (line 30 minus line 40)****	351,450	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 351,450	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	16	16	$ 539	$ 33.69	1
2	Assistant Director of Nursing	2,255	2,566	74,226	28.93	2
3	Registered Nurses	13,274	14,339	327,127	22.81	3
4	Licensed Practical Nurses	55,290	60,640	1,239,906	20.45	4
5	Nurse Aides & Orderlies	128,726	138,125	1,212,952	8.78	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,198	7,936	105,252	13.26	8
9	Activity Director	3,131	3,276	41,329	12.62	9
10	Activity Assistants	14,864	15,877	117,652	7.41	10
11	Social Service Workers	11,576	12,658	143,589	11.34	11
12	Dietician	1,780	2,020	24,059	11.91	12
13	Food Service Supervisor	1,922	2,159	30,775	14.25	13
14	Head Cook					14
15	Cook Helpers/Assistants	32,746	35,210	271,572	7.71	15
16	Dishwashers					16
17	Maintenance Workers	4,702	5,060	57,316	11.33	17
18	Housekeepers	29,895	31,756	231,527	7.29	18
19	Laundry	10,732	11,757	87,031	7.40	19
20	Administrator	73	89	1,535	17.25	20
21	Assistant Administrator	1,686	1,985	37,244	18.76	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,659	8,355	79,648	9.53	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,942	2,182	21,849	10.01	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	329,467	356,006	$ 4,105,128 *	$ 11.53	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	507	$ 12,584	01-03	35
36	Medical Director	72	9,000	09-03	36
37	Medical Records Consultant	Monthly	3,784	10-03	37
38	Nurse Consultant	Monthly	200	10-03	38
39	Pharmacist Consultant	Monthly	1,200	10-03	39
40	Physical Therapy Consultant	26	1,377	10a-03	40
41	Occupational Therapy Consultant	16	837	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	16	810	10a-03	43
44	Activity Consultant	31	2,292	11-03	44
45	Social Service Consultant	Monthly	1,056	12-03	45
46	Other(specify)				46
47	CCI Salary/Consultant		111,944	Various	47
48					48
49	TOTAL (lines 35 - 48)	668	$ 145,084		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,333	$ 66,639	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	1,333	$ 66,639		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Scott Braun	Administrator	0	$ 1,535
Elizabeth Williams	Asst Administrator	0	37,244
Additional Administrator & Asst Admin salary paid through CCI			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 38,779

B. Administrative - Other

Description	Amount
Eric Rothner	$ 180,000
Alan Abrams	12,000
Ron Abrams	12,000
See Supplemetal Schedule	99,482
TOTAL (agree to Schedule V, line 17, col. 3)	$ 303,482
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Care Centers, Inc.	Home Office Expense	$ 191,520
Care Centers, Inc.	Ancillary Admin Expense	27,360
Care Centers, Inc.	Bookkeeping	46,512
Care Centers, Inc.	Accounting	15,000
FR&R	Accounting	17,000
Winston & Strawn	Legal	6,827
Ashman & Stein	Legal	1,191
Care Centers, Inc.	Legal	20,805
Diawa	Legal	3,643
Personnel Planners	Unemploy Consulting	2,381
TEG Services	Utility Management Service	525
See Supplemetal Schedule		54,164
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 386,928

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 138,859
Unemployment Compensation Insurance	63,668
FICA Taxes	280,991
Employee Health Insurance	170,750
Employee Meals	36,135
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	20,794
Pension Expense	33,106
Holiday Expense	3,653
Misc Emply Welfare	8,458
TOTAL (agree to Schedule V, line 22, col.8)	$ 756,413

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	15,704
Health Care Worker Background Check	
(Indicate # of checks performed 120)	1,215
Advertising & Promotion	31,357
Licenses & Fees	11,545
Dues & Subscriptions	8,532
Yellow Page Advertising	148
Care Center Alloc	1,515
Less: Public Relations Expense	( )
Non-allowable advertising	(31,357)
Yellow page advertising	(148)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 38,711

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	340
Care Center Alloc	1,542
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,882

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Washington Heights N H # 0042044 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N H **#** 0042044 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on LTC - $10,820.88**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,870** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **124,830**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **36,135** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: **N0** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **No**
Attach invoices and a summary of services for all architect and appraisal fees.